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1348(c)	Every health care service plan that establishes an antifraud plan pursuant to subdivision (a) shall provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report shall include the number of cases prosecuted to the extent known by the plan. This report may also include recommendations by the plan to improve efforts to combat health care fraud.
1373.21(b); 1300.73.21(a)(2)	1373.21(b): A copy of any modified written decision, including the amount of the award and other relevant terms of the award, the reasons for the award rendered, the name of the arbitrator or arbitrators, but excluding the names of the enrollee, the plan, witnesses, attorneys, providers, health plan employees, and health facilities, shall be provided to the department on a quarterly basis. The department shall make these modified decisions available to the public upon request. 1300.73.21(a)(2): On a quarterly basis, plans shall provide the Department with redacted copies of all written arbitration decisions. The plan shall be responsible for redacting the written arbitration decisions ensuring that the names of the enrollee, the plan, witnesses, attorneys, providers, plan employees and health facilities have been removed from the decision. The redacted arbitration decisions will be available for public inspection on the Department's web page (*www.dmhc.ca.gov*).
1373.21(c); 1300.73.21(a)(1)	1373.21(c): Subdivision (b) shall not preclude the department from requesting and securing from any plan copies of complete arbitration decisions issued pursuant to subdivision (a) for the purposes of administering this chapter. 1300.73.21(a)(1): Within thirty (30) days of receiving a written arbitration decision, the plan shall provide a copy of the complete arbitration decision to the Department. The complete arbitration decision shall have no part of the decision altered or redacted. The complete arbitration decision shall indicate the prevailing party, the amount and other relevant terms of any award, and the reasons for the decision.
1384(a)	Within 90 days after receipt of a request from the director, a plan or other person subject to this chapter shall submit to the director an audit report containing audited financial statements covering the 12-calendar months next preceding the month of receipt of the request, or another period as the director may require.
1384(b)	On or before 105 days after the date of a notice of surrender or order of revocation, a plan shall file with the director a closing audit report containing audited financial statements. The reporting period for the closing

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	audit report shall be the 12-month period preceding the date of the notice of surrender or order of revocation, or for another period as the director may specify. This report shall include other relevant information as specified by rule of the director. The director shall not consent to a surrender and an order of revocation shall not be considered final until the closing audit report has been filed with the director and all concerns raised by the director there from have been resolved by the plan, as determined by the director. For good cause, the director may waive the requirement of a closing audit report.
1300.84.7	(a) Any plan whose purposes involve any charitable or public purposes shall provide a special report to the Director upon filing with the Attorney General any notice, request, or other materials pursuant to any law administered by the Attorney General and relating to matters, which will or may have any financial effect on or implications for the plan. Such special report shall include the information provided to the Attorney General together with representations as to whether the transactions, actions, or other facts set forth in the materials submitted to the Attorney General will or may have any deleterious effect on the financial condition of the plan. (b) Any plan whose purposes involved any charitable or public purposes shall provide a special report to the Director upon engaging in any transaction to which the corporation is a party and in which one or more of its directors has a material financial interest, if such transaction will or may have any material financial effect on or implications for the plan. Such special report shall specifically describe the transaction and shall contain representations as to whether the transaction will or may have any deleterious effect on the financial condition or operations of the plan. (c) Any filing pursuant to this section may be combined with any appropriate filings pursuant to Article 2, Part 11, Division 2, Title 1 of the Corporations Code and may utilize common exhibits, subject to the provisions of Section 1300.824(c).
1399.70	(a) In addition to the information required by subdivision (a) of Section 1399.73, a nonprofit health care service plan submitting an application to the director to restructure or convert its activities pursuant to this article shall submit to the director a copy of all of its original and amended articles of incorporation and bylaws, as well as a report summarizing the activities undertaken by the plan to meet its nonprofit obligations as directed by the director. . . . .

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1300.71(q)	Required Reports. (1) Within 60 days of the close of each calendar quarter, the plan shall disclose to the Department in a single combined document: (A) any emerging patterns of claims payment deficiencies; (B) whether any of its claims processing organizations or capitated providers failed to timely and accurately reimburse 95% of its claims (including the payment of interest and penalties) consistent with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28; and (C) the corrective action that has been undertaken over the preceding two quarters. The first report from the plan shall be due within 45 days after the close of the calendar quarter that ends 120 days after the effective date of these regulations. (2) Within 15 days of the close of each calendar year, beginning with the 2004 calendar year, the plan shall submit to the Director, as part of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report as specified in section 1367(h) of the Health and Safety Code and section 1300.71.38(k) of title 28, in an electronic format (to be supplied by the Department), information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers with each of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. The Annual Plan Claims Payment and Dispute Resolution Mechanism Report for 2004 shall include claims payment and dispute resolution data received from October 1, 2003 through September 30, 2004. Each subsequent Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall include claims payment and dispute resolution data received for the last calendar quarter of the year preceding the reporting year and the first three calendar quarters for the reporting year. (A) The claims payment compliance status portion of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report shall: (i) be based upon the plan's claims processing organization's and the plan's capitated provider's Quarterly Claims Payment Performance Reports submitted to the plan and upon the audits and other compliance processes of the plan consistent with section 1300.71.38(m) and (ii) include a detailed, informative statement: (1) disclosing any established or documented patterns of claims payment deficiencies, (2) outlining the corrective action that has been undertaken, and (3) explaining how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results). The information

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	provided pursuant to this section shall be submitted with the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant to section 1007 of title 28.
1363.06(d)	Health care service plans, except specialized health care service plans, shall submit the following to the department by January 31, 2003, and annually thereafter: (1) A summary explanation of the following for each product described in subdivision (a). (A) Eligibility requirements. (B) The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside. (C) When and under what circumstances benefits cease. (D) The terms under which coverage may be renewed. (E) Other coverage that may be available if benefits under the described benefit package cease. (F) The circumstances under which choice in the selection of physicians and providers is permitted. (G) Lifetime and annual maximums. (H) Deductibles. (2) A summary explanation of coverage for the following, together with the corresponding co-payments and limitations, for each product described in subdivision (a): (A) Professional services. (B) Outpatient services. (C) Hospitalization services. (D) Emergency health coverage. (E) Ambulance services. (F) Prescription drug coverage. (G) Durable medical equipment. (H) Mental health services. (I) Residential treatment. (J) Chemical dependency services. (K) Home health services.

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	(L) Custodial care and skilled nursing facilities. (3) The telephone number or numbers that may be used by an applicant to access a health care service plan customer service representative and to request additional information about the plan contract. (4) Any other information specified by the department in the template.
1367.03(g)(2)	Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.
1300.84.6	(a) On or before May 15th of each year, each licensed plan shall file a report in the following form and containing the information specified therein: [Form]
1383	Every plan that is a health maintenance organization qualified under Section 1310(d) of Title XIII of the federal Public Health Service Act, shall provide the department with a copy of the reports the plan files annually with the United States Department of Health, Education, and Welfare pursuant to Title XIII of the federal Public Health Service Act.
1300.84.2	Within 45 days after the close of each quarter of its fiscal year, each licensed plan shall file with the Director its report consisting of the following information: (a) Financial statements (which need not be certified) prepared in accordance with generally accepted accounting principles, prepared on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c) of the Act, unless the plan receives the written approval of the Director to vary from that basis and the variance is adequately noted in its report under this section. The financial statements shall include the following statements, reports and schedules contained in the "HMO Annual Reporting Form" identified in Section 1300.84.06(a) of these rules for the period covered by the report: (1) First page: "Statement"; (2) Report #1-Part A: Balance Sheet Assets; (3) Report #1-Part B: Balance Sheet Liabilities and Net Worth;

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	(4) Report #2: Statement of Revenue and Expenses; (5) Report #3: Statement of Financial Position and Net Worth; (6) Report #4: Enrollment and Utilization Table; and (7) Section I of Schedule F: Unpaid Claims Analysis. (b) The information required pursuant to Section 1300.84.06(b) of these rules for the period covered by the report, except as otherwise specified.
1384(c); 1300.84.06	1384(c): Except as otherwise provided in this subdivision, each plan shall submit financial statements prepared as of the close of its fiscal year within 120 days after the close of the fiscal year. The financial statements referred to in this subdivision and in subdivisions (a) and (b) of this section shall be accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant. The audits shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director. However, financial statements from public entities or political subdivisions of the state whose audits are conducted by a county grand jury shall be submitted within 180 days after the close of the fiscal year and need not include a report, certificate, or opinion by an independent certified public accountant or an independent public accountant, and the audit shall be conducted in accordance with governmental auditing standards. 1300.84.06: The annual report required of a plan pursuant to subdivision (c) of Section 1384 of the Act shall include or be accompanied by the following information for the period covered by the report, except as otherwise specified: (a) The "Health Maintenance Organization Financial Report of Affairs and Conditions Form" as adopted by the National Association of Insurance Commissioners commonly known as the "HMO Annual Reporting Form" and the "Orange Blank" published by the Brandon Insurance Service Company. The "HMO Annual Reporting Form," revised 1989, is incorporated by reference. (b) Sufficient and appropriate supplemental information to provide adequate disclosure of at least the following: (1) An explanation of the method of calculating the provision for incurred and unreported claims. (2) Accounts and notes receivable from officers, directors, owners or affiliates, including the name of the

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	debtor, nature of the relationship, nature of the receivable and its terms. (3) Donated materials or services received by the plan for the period of the financial statements and the donor's name and affiliation with the plan, together with an explanation of the method used in determining the valuation of such materials or services. (4) Forgiven debt or obligations during the period of the financial statements, including the creditor's name and affiliation with the plan and a summary of how the obligation arose. (5) A calculation of the plan's tangible net equity in accordance with Section 1300.76 of these rules. Such calculation shall include disclosure of the following information used to determine the required amount of tangible net equity pursuant to Section 1300.76(a) and (b): (A) Revenues 1. Two percent of the first $150 million, or $7.5 million for specialized plans, of annualized premium revenues; 2. One percent of annualized premium revenues in excess of $150 million, or $7.5 million for specialized plans; 3. Sum of 1. and 2. above. (B) Healthcare Expenditures 1. Eight percent of the first $150 million, or $7,500,00 for specialized plans of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis. 2. Four percent of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million, or $7,500,000 for specialized plans; 3. Four percent of annualized hospital expenditures paid on a managed hospital payment basis. 4. Sum of 1., 2. and 3. above. (6) The percentage of administrative costs to revenue obtained from subscribers and enrollees. (7) The amount of health care expenses incurred during the six-month period immediately preceding the date of the report, which were or will be paid to non-contracting providers or directly reimbursed to subscribers and enrollees.

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	(8) Total costs for health care services for the immediately preceding six months. (9) If the amount of health care expenses incurred during the six month period immediately preceding the date of the report which were or will be paid to non-contracting providers or directly reimbursed to subscribers and enrollees exceeds 10% of the total costs for health care services for the immediately preceding six months, the following information, determined as of the date of the report, shall be provided: (A) Amount of all claims for non-contracting provider services received for reimbursement but not yet processed. (B) Amount of all claims for non-contracting provider services denied for reimbursement during the previous 60 days. (C) Amount of all claims for non-contracting provider services approved for reimbursement but not yet paid. (D) An estimate of the amount of claims for non-contracting provider services incurred, but not reported. (E) A calculation of compliance with Section 1377(a) as determined in accordance with such section.
1368(c), 1300.68(f)	1368 : (c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director: "Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights." If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include

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	a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5. 1300.68(f): (1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter. (2) The quarterly report shall include: (A) The licensee's name, quarter and date of the report; (B) The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan; (C) A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration. (D) The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized. (E) The quarterly report shall not contain personal or confidential information with respect to any enrollee.

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	(3) The quarterly report shall be verified by an officer authorized to act on behalf of the plan. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to the plan application. (4) The quarterly report shall be filed in the format specified in subsection (i).
1373.6(a)(3)	If the health care service plan does not provide coverage under an individual health care service plan contract, it shall offer a health benefit plan contract that is the same as a health benefit contract offered to a federally eligible defined individual pursuant to Section 1366.35. The health care service plan may offer either the most popular health maintenance organization model plan or the most popular preferred provider organization plan, each of which has the greatest number of enrolled individuals for its type of plan as of January 1 of the prior year, as reported by plans that provide coverage under an individual health care service plan contract to the department or the Department of Insurance by January 31, 2003, and annually thereafter. A health care service plan subject to this paragraph shall provide this coverage with the same cost-sharing terms and at the same premium as a health care service plan providing coverage to that individual under an individual health care service plan contract pursuant to Section 1399.805. The health care service plan shall file the health benefit plan it will offer, including the premium it will charge and the cost-sharing terms of the plan, with the Department of Managed Health Care.
1389.3(c)	On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.
1358.22	(a) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement contract: (1) Contract number. (2) Date of issuance.

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	(b) The items set forth above shall be grouped by enrollee.
1358.225	(a) Every issuer shall, by June 30 of each year, file with the director a list of its Medicare supplement contracts offered or issued or outstanding in this state as of the end of the previous calendar year. (b) The list shall identify the filing issuer by name and address, shall identify each type of contract it offers by name and form number, if one is used, and shall differentiate between contracts filed with and approved by the director in years prior to the previous calendar year, and those filed and approved in the previous calendar year. (c) The list shall specifically identify all of the following: (1) Contracts that are issued and outstanding in this state but are no longer offered for sale. (2) Contracts that, for any reason, were not filed and approved by the director. (3) Contracts for which the director's approval was withdrawn within the previous calendar year. (d) The director shall, on or before the first day of September of each year provide the secretary with a list identifying each contract by name and address and the information required to be submitted by this section.
1358.10(k)(6)	The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.
1358.146	The following format shall be used for reporting loss ratio experience: [form]
1358.14(b)	1) With respect to refund or credit calculations, an issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form required by the director (NAIC Appendix A) for each type of coverage in a standard Medicare supplement benefit plan. (2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of contract offered by the issuer. For purposes of the refund or credit calculation, experience on contracts issued within the reporting year shall be excluded. (3) For the purposes of this section, with respect to contracts advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual

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	contracts, including all group contracts subject to an individual loss ratio standard when issued, combined and all other group contracts combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003. (4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds ten dollars ($10). The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against prepaid or periodic charges due shall be made by September 30 following the experience year upon which the refund or credit is based.
1377(b); 1377(c); 1300.77.3	1377(b): Whenever the reimbursements described in this section exceed 10 percent of the plan's total costs for health care services over the immediately preceding six months, the plan shall file a written report with the director containing the information necessary to determine compliance with subdivision (a) no later than 30 business days from the first day of the month. Upon an adequate showing by the plan that the requirements of this section should be waived or reduced, the director may waive or reduce these requirements to an amount as the director deems sufficient to protect subscribers and enrollees of the plan consistent with the intent and purpose of this chapter. 1377 (c) Every plan which reimburses providers of health care service on a fee-for-services basis; or which directly reimburses its subscribers or enrollees, to an extent exceeding 10 percent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims. Upon a determination by the director that the estimate is inadequate, the director may require the plan to increase its estimate of incurred and unreported claims. Every plan shall promptly report to the director whenever these reimbursables exceed 10 percent of its total expenditures for health care services. As used herein, the term "fee-for-services" refers to the situation where the amount of reimbursement paid by the plan to providers of service is determined by the amount and type of service rendered by the provider of service. 1300.77.3: a) Every plan which reimburses providers of health care services or subscribers and enrollees in the manner described in subdivision (a) or (b) of Section 1377 of the Act shall make and maintain as part of its records a computation for each calendar month and calendar quarter of reimbursements made, classified

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	as provided in Section 1377, and showing the percentage of each class of reimbursements made to total expenditures for health care services during such month or quarter. (b) When a report is required by subdivision (a) of Section 1377 of the Act, such report shall be filed with the Director no later than 30 business days after the close of the calendar quarter. (c) When a report is required by subdivision (b) of Section 1377 of the Act, such report shall be filed with the Director no later than 30 business days after the close of the calendar month during which actual reimbursements made, or the amount estimated for incurred and unreported claims, exceeds 10 percent of its total expenditures for health care services.
1374.64(b)(1)(A)(ii); 1374.64(b)(2)(A)(ii); 1300.84.3(d)	1374.64(b)(1)(A)(ii): The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 10 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter. 1374.64(b)(2)(A)(ii): The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 10 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter. 1300.84.3(d): Each plan shall, upon the occurrence of any of the events specified below, file a report with the Director within 30 days of the close of the month for which such condition is noted, and each month thereafter until notified by the Director to discontinue such reports. Each such report shall consist of a balance sheet and statement of operations of the plan, which need not be certified, a calculation of tangible net equity in accordance with Section 1300.76 of these rules, and the verification required by subsection (e) of this rule. Such financial statements must be prepared on a basis consistent with the financial statements furnished by the plan pursuant to Section 1300.84.2 of these rules. The events the occurrence of which shall require reporting under this section are the following: (1) The tangible net equity of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), is less than the following:

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	(A) 200% of the minimum tangible net equity required by Section 1300.76(c)(1); (B) 155% of the minimum tangible net equity required by Section 1300.76(c)(2); (C) 148% of the minimum tangible net equity required by Section 1300.76(c)(3); (D) 137% of the minimum tangible net equity required by Section 1300.76(c)(4); (E) 136% of the minimum tangible net equity required by Section 1300.76(c)(5); (F) 130% of the minimum tangible net equity required by Section 1300.76(c)(6); (G) 130% of the minimum tangible net equity required by Section 1300.76(a) or (b), as specified. (2) The statement of operations of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), reflects a loss during any month the amount of which exceeds the difference between the tangible net equity of the plan (or the combined entity) as of the end of such month and the minimum net equity required by Section 1300.76 of these rules. (3) The plan has not been licensed for twelve (12) months.
1367(h)(3), 1300.71.38(k)	1367(h): (3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes. 1300.71.38(k): Required Reports. Beginning with the 2004 calendar year and for each subsequent year, the plan shall submit to the Department no more than fifteen (15) days after the close of the calendar year, an "Annual Plan Claims Payment and Dispute Resolution Mechanism Report," described in part in Section 1300.71(q) of this regulation, on an electronic form to be supplied by the Department Managed Health Care pursuant to section 1300.41.8 of title 28 containing the following, which shall be reported based upon the date of receipt of the provider dispute or amended provider dispute: (1) Information on the number and types of providers using the dispute resolution mechanism; (2) A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as

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	individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and (3) A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans. The information provided pursuant to this paragraph shall be submitted with, but separately from the other portions of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant section 1007 of title 28. (4) The first report shall be due on or before January 15, 2005.
1375.4(b)(6); 1300.75.4.3(b)	1375.4(b)(6): Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the director, a registration process for the risk-bearing organizations. 1300.75.4.3(b): Plan Annual Survey. Along with the quarterly report due May 15,2001, and for the report due by May 15 of each subsequent year (i.e., an annual reporting period), every plan shall submit an annual survey report in an electronic format to the Director, containing the following information, as of December 31 of the prior calendar year, for each organization with which the plan has a risk arrangement: (1) For the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose, in a separate matrix for each product line, the allocation of risk between the plan, the organization, and the facility by major expense category. For each of the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose the number of covered lives and the counties primarily served by the organization. (2) The report shall disclose whether the plan provides stop-loss insurance to the organization, and if so, the nature of any and all stop-loss arrangements.
1375.4(b)(6); 1300.75.4.3(a)	1375.4(b)(6): Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the director, a registration process for the risk-bearing organizations.

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Citation	Text
	1300.75.4.3(a): Plan Quarterly Survey. Every plan that contracts with an organization shall, by May 15, 2001, and not more than forty-five (45) days after the close of each subsequent calendar quarter, submit a quarterly survey report in an electronic format to the Director listing all its contracting organizations, including their names, addresses, contact persons, telephone numbers, and number of enrollees assigned to the organization as of the last day of the quarter being reported.
1300.84.3(d)	Each plan shall, upon the occurrence of any of the events specified below, file a report with the Director within 30 days of the close of the month for which such condition is noted, and each month thereafter until notified by the Director to discontinue such reports. Each such report shall consist of a balance sheet and statement of operations of the plan, which need not be certified, a calculation of tangible net equity in accordance with Section 1300.76 of these rules, and the verification required by subsection (e) of this rule. Such financial statements must be prepared on a basis consistent with the financial statements furnished by the plan pursuant to Section 1300.84.2 of these rules. The events the occurrence of which shall require reporting under this section are the following: (1) The tangible net equity of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), is less than the following: (A) 200% of the minimum tangible net equity required by Section 1300.76(c)(1); (B) 155% of the minimum tangible net equity required by Section 1300.76(c)(2); (C) 148% of the minimum tangible net equity required by Section 1300.76(c)(3); (D) 137% of the minimum tangible net equity required by Section 1300.76(c)(4); (E) 136% of the minimum tangible net equity required by Section 1300.76(c)(5); (F) 130% of the minimum tangible net equity required by Section 1300.76(c)(6); (G) 130% of the minimum tangible net equity required by Section 1300.76(a) or (b), as specified. (2) The statement of operations of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), reflects a loss during any month the amount of which exceeds the difference between the tangible net equity of the plan (or the combined entity) as of the end of such month and the minimum net equity required by Section 1300.76 of these rules. (3) The plan has not been licensed for twelve (12) months.

Addendum to Periodic Reports that Licensed Plans are Required to Submit to the DMHC

Citation	Text
	(e) Each report required to be furnished by a plan pursuant to subsection (d) of this rule shall be verified by a principal officer of the plan as follows: I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this report and know the contents thereof, and that the statements therein are true and correct. Executed at _____ (City and State) on _____ (Today's Date – Month Day, Year) Signature: